TRAIL WEST
FAMILY DENTISTRY

**Personal Information**

Patient First/Last Name:_____ Preferred Name:_____

DOB:_____ Gender:_____ SS#_____ Marital Status: ☐Single ☐Married ☐Widowed

Cell:_____ Home:_____ Work:_____

Email:_____

Address:_____ City, State:_____Zip:_____

Emerg Contact #:_____Name:_____Relation:_____

*How did you hear about us?_____

**Dental Insurance**

Insurance Company:_____ Employer:_____

Name of Insured:_____ DOB:_____ Relation to Patient:_____

Insured SS #:_____ Member/Subscriber ID:_____

Secondary Insurance:_____ Employer:_____

Name of Insured:_____ DOB:_____ Relation to Patient:_____

Insured SS #:_____ Member/Subscriber ID:_____

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**Acknowledgement of Receipt of Notice of Privacy Practices**

*You may refuse to sign this acknowledgement.*

I, _____, have received/am aware that I have access to a copy of this office's Notice
*(Patient/Guardian Name PRINTED)*

of Privacy Practices (provided upon request).

X_____ _____
*Patient/Guardian Signature* *Date*

THIS SECTION FOR OFFICE USE ONLY

*We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:*

☐ Individual refused to sign.
☐ Communication barriers prohibited obtaining the acknowledgement.
☐ An emergency situation prevented us from obtaining acknowledgement.
☐ Other (Please specify): _____

# Dental/Health History

TRAIL WEST FAMILY DENTISTRY

▪ **We understand that many patients feel anxious in the dental chair, so we offer Nitrous Oxide (Laughing Gas) for treatment. Would you be interested in discussing this option with Dr. Gould and his staff?** ☐ YES ☐ NO

▪ **Reason(s) for your visit today:** _____

▪ **Previous Dentist:** _____ **Date of Last Dental Care / Xrays:** _____

▪ **How often do you floss?** _____ **How often do you brush?** _____

▪ **Mark (with an X) any of the following that you are having issues with presently:**

☐ Bad Breath
☐ Loose Teeth
☐ Bleeding Gums
☐ Broken Fillings
☐ Sensitivity to Hot
☐ Sensitivity to Cold
☐ Sensitivity to Sweets
☐ Sensitivity to Biting
☐ Food Between Teeth
☐ Sores or Growths in Your Mouth
☐ Stained/Discolored Teeth
☐ Crooked/Crowded Teeth
☐ Clicking/Popping Jaw
☐ Grinding Teeth
☐ Periodontitis/Gum Disease

▪ **Primary Care Physician**: _____ **Date of Last Visit:** _____

▪ **Mark (with an X) any of the following for which you have ever been treated/conditions that apply to you:**

☐ Anemia
☐ Anxiety
☐ Arthritis/Rheumatism
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma/Respiratory Problems
☐ Blood Disease/Hemophilia
☐ Cancer/Tumor
☐ Circulatory Problems
☐ Cough, Persistent
☐ Diabetes - Type ☐1 ☐2
☐ Epilepsy/Seizures
☐ Fainting
☐ Headaches/Migraines
☐ Heart Problems
☐ Hepatitis - Type ☐A ☐B ☐C
☐ High or ☐ Low Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain/TMJ
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Scarlet Fever
☐ Stroke
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Venereal Disease

▪**List any other serious illnesses, conditions, operations:** _____

▪ **Current Medications (if none, write NONE):** _____

_____

▪ **Have you ever taken medication for osteoporosis? ☐Yes ☐No If yes, please list:** _____

▪ **Allergies (Mark with an X any that apply):**

☐ None ☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Local Anesthesia ☐ Penicillin ☐ Sulfa ☐ Latex

☐ Other: _____

▪ **Are you required to take antibiotic premedication for dental visits?** ☐Y ☐N If yes, for what?_____

***FOR WOMEN ONLY* -** Mark (with an X) any that apply:

☐ Pregnant ☐ Nursing ☐ Taking birth control pills ☐ **None of These**

_____
Patient Name (Printed)

X_____ _____
Patient/Guardian signature Date